

CASE ABSTRACT FOR MALPRACTICE CLAIMS			1. DATE OF REPORT (YYYYMMDD)		2. CLAIMANT LAST NAME		REPORT CONTROL SYMBOL DD-HA(AR)1782	
3. TYPE OF REPORT (<i>X one</i>)						4. DATES OF ACT(S) OR OMISSION(S) (YYYYMMDD)		
<input type="checkbox"/> a. INITIAL		<input type="checkbox"/> b. CORRECTION OR ADDITION		<input type="checkbox"/> a. BEGINNING DATE		<input type="checkbox"/> b. ENDING DATE		
<input type="checkbox"/> c. REVISION TO ACTION		<input type="checkbox"/> d. VOID PREVIOUS REPORT						
5. DATE CLAIM FILED (YYYYMMDD)		6. DATE OF JUDGMENT OR SETTLEMENT (YYYYMMDD)		7. MEDICAL TREATMENT FACILITY				
				<input type="checkbox"/> a. NAME			<input type="checkbox"/> b. DMIS CODE	
8. PRACTITIONER INFORMATION								
<input type="checkbox"/> a. NAME (<i>Last, First, Middle Initial</i>)				<input type="checkbox"/> b. SSN		<input type="checkbox"/> c. DATE OF BIRTH (YYYYMMDD)		
<input type="checkbox"/> d. NAME OF PROFESSIONAL SCHOOL ATTENDED				<input type="checkbox"/> e. DATE GRADUATED (YYYYMMDD)		<input type="checkbox"/> f. SPECIALTY CODE		
<input type="checkbox"/> g. STATUS (<i>X one</i>)								
<input type="checkbox"/> (1) Army		<input type="checkbox"/> (3) Air Force		<input type="checkbox"/> (5) Civilian GS		<input type="checkbox"/> (7) Partnership External		<input type="checkbox"/> (9) Non-Personal Services Contract
<input type="checkbox"/> (2) Navy		<input type="checkbox"/> (4) PHS		<input type="checkbox"/> (6) Partnership Internal		<input type="checkbox"/> (8) Personal Services Contract		
<input type="checkbox"/> h. SOURCE OF ACCESSION (<i>X all that apply</i>)								
<input type="checkbox"/> (1) Military				<input type="checkbox"/> (2) Civilian				
<input type="checkbox"/> (a) Volunteer		<input type="checkbox"/> (d) National Guard		<input type="checkbox"/> (a) Civil Service		<input type="checkbox"/> (d) Foreign National (Local Hire)		
<input type="checkbox"/> (b) Armed Forces Health Pro- fessional Scholarship Program		<input type="checkbox"/> (e) Reserve		<input type="checkbox"/> (b) Contracted		<input type="checkbox"/> (e) Other (<i>Specify</i>)		
<input type="checkbox"/> (c) Uniformed Services Univer- sity of Health Sciences		<input type="checkbox"/> (f) Other (<i>Specify</i>)		<input type="checkbox"/> (c) Consultant				
<input type="checkbox"/> i. LICENSING INFORMATION								
<input type="checkbox"/> (1) State of License		<input type="checkbox"/> (2) License Number		<input type="checkbox"/> (1) State of License		<input type="checkbox"/> (2) License Number		
9. TYPE OF PRACTITIONER AND SPECIALTY (FIELD OF LICENSURE) (<i>X all that apply</i>)								
<input type="checkbox"/> a. PHYSICIAN DEGREE		<input type="checkbox"/> M.D. (010)		<input type="checkbox"/> D.O. (020)				
<input type="checkbox"/> (1) Highest Level of Specialization								
<input type="checkbox"/> (a) Board Certified		<input type="checkbox"/> (b) Residency Completed		<input type="checkbox"/> (c) In Residency (015/025)		<input type="checkbox"/> (d) No Residency		
<input type="checkbox"/> (2) Primary Specialty		<input type="checkbox"/> (h) Internal Medicine (Cont.)		<input type="checkbox"/> (l) Otorhinolaryngology		<input type="checkbox"/> (t) Surgery, General (Cont.)		
<input type="checkbox"/> (a) In Training		<input type="checkbox"/> (h.c) Infectious Disease		<input type="checkbox"/> (m) Orthopedics		<input type="checkbox"/> (t.d) Oncology		
<input type="checkbox"/> (b) General Practice (GMO)		<input type="checkbox"/> (h.d) Nephrology		<input type="checkbox"/> (n) Pathology		<input type="checkbox"/> (t.e) Pediatric		
<input type="checkbox"/> (c) Anesthesiology		<input type="checkbox"/> (h.e) Pulmonary		<input type="checkbox"/> (o) Pediatrics		<input type="checkbox"/> (t.f) Peripheral Vascular		
<input type="checkbox"/> (d) Aviation Medicine		<input type="checkbox"/> (h.f) Rheumatology		<input type="checkbox"/> (p) Physical Medicine		<input type="checkbox"/> (t.g) Plastic		
<input type="checkbox"/> (e) Dermatology		<input type="checkbox"/> (h.g) Tropical Medicine		<input type="checkbox"/> (q) Preventive Medicine		<input type="checkbox"/> (u) Underseas Medicine		
<input type="checkbox"/> (f) Emergency Medicine		<input type="checkbox"/> (h.h) Allergy/Immunology		<input type="checkbox"/> (r) Psychiatry		<input type="checkbox"/> (v) Urology		
<input type="checkbox"/> (g) Family Practice		<input type="checkbox"/> (h.i) Cardiology		<input type="checkbox"/> (s) Radiology		<input type="checkbox"/> (w) Intensivist		
<input type="checkbox"/> (h) Internal Medicine		<input type="checkbox"/> (h.j) Endocrinology		<input type="checkbox"/> (t) Surgery, General		<input type="checkbox"/> (x) Neonatologist		
<input type="checkbox"/> (h.a) Gastroenterology		<input type="checkbox"/> (i) Neurology		<input type="checkbox"/> (t.a) Cardio-Thoracic		<input type="checkbox"/> (y) Other (<i>Specify</i>)		
<input type="checkbox"/> (h.b) Hematology - Oncology		<input type="checkbox"/> (j) Obstetrics/Gynecology		<input type="checkbox"/> (t.b) Colon-Rectal				
		<input type="checkbox"/> (k) Ophthalmology		<input type="checkbox"/> (t.c) Neurosurgery				
<input type="checkbox"/> (3) Board Certification(s)								
<input type="checkbox"/> b. DENTIST								
		<input type="checkbox"/> DENTIST (030)						
<input type="checkbox"/> (1) Highest Level of Specialization				<input type="checkbox"/> (2) Primary Specialty				
<input type="checkbox"/> (a) Board Certified		<input type="checkbox"/> (c) In Residency (035)		<input type="checkbox"/> (a) General Dental Officer		<input type="checkbox"/> (c) Other (<i>Specify</i>)		
<input type="checkbox"/> (b) Residency Completed		<input type="checkbox"/> (d) No Residency		<input type="checkbox"/> (b) Oral Surgeon				
<input type="checkbox"/> (3) Board Certification(s)								
<input type="checkbox"/> c. OTHER PRACTITIONERS		<input type="checkbox"/> OTHER PRACTITIONERS						
<input type="checkbox"/> Audiologist (400)		<input type="checkbox"/> Nurse Anesthetist (110)		<input type="checkbox"/> Optometrist (636)		<input type="checkbox"/> Registered Nurse (100)		
<input type="checkbox"/> Clinical Dietician (200)		<input type="checkbox"/> Nurse Midwife (120)		<input type="checkbox"/> Physical Therapist (430)		<input type="checkbox"/> Emergency Medical Technician		
<input type="checkbox"/> Clinical Pharmacist (050)		<input type="checkbox"/> Nurse Practitioner (130)		<input type="checkbox"/> Physician Assistant (642)		<input type="checkbox"/> Other (<i>Specify</i>)		
<input type="checkbox"/> Clinical Psychologist (370)		<input type="checkbox"/> Occupational Therapist (410)		<input type="checkbox"/> Podiatrist (350)				
<input type="checkbox"/> Clinical Social Worker (300)				<input type="checkbox"/> Speech Pathologist (450)				

10. PATIENT DEMOGRAPHICS							
a. NAME <i>(Last, First, Middle Initial)</i>			b. SEX <i>(X one)</i> <input type="checkbox"/> (1) Male <input type="checkbox"/> (2) Female <input type="checkbox"/> (3) Unknown			c. AGE	
d. STATUS <i>(X and complete as applicable)</i> <input type="checkbox"/> (1) Dependent of Active Duty <input type="checkbox"/> (3) Retired Member <input type="checkbox"/> (5) Active Duty <input type="checkbox"/> (2) Dependent of Retired Member <input type="checkbox"/> (4) Civilian Emergency <input type="checkbox"/> (6) Other <i>(Specify)</i>						e. SSN OF SPONSOR	
11. DIAGNOSES		ICD9-CM CODE		12. PROCEDURES		ICD9-CM CODE	
a. <i>(Primary)</i>				a. <i>(Principal)</i>			
b.				b.			
c.				c.			
13. PATIENT ALLEGATION(S) OF NEGLIGENT CARE							
a. DESCRIPTION OF THE ACTS OR OMISSIONS AND INJURIES UPON WHICH THE ACTION OR CLAIM WAS BASED <i>(Limit to 300 characters.)</i>							
b. ACT OR OMISSION CODE(S) <i>(Refer to table on Page 4)</i>						c. CLINICAL SERVICE CODE	
<input type="checkbox"/> (1) Primary Act or Omission Code		<input type="checkbox"/> (2) Additional Act or Omission Code		<input type="checkbox"/> (1) Primary			
<input type="checkbox"/> (3) Additional Act or Omission Code		<input type="checkbox"/> (4) Additional Act or Omission Code		<input type="checkbox"/> (2) Secondary			
<input type="checkbox"/> (5) Additional Act or Omission Code		<input type="checkbox"/> (6) Additional Act or Omission Code		<input type="checkbox"/> (3) Tertiary			
d. DESCRIPTION OF FINDINGS ON WHICH THE ACTION OR CLAIM WAS PAID							
14. MALPRACTICE CLAIM MANAGEMENT							
a. AMOUNT CLAIMED		b. ADJUDICATIVE BODY CASE NUMBER			c. ADJUDICATIVE BODY NAME		d. DATE OF PAYMENT <i>(YYYYMMDD)</i>
e. OUTCOME <i>(X one)</i> <input type="checkbox"/> (1) Administratively Settled (Service) <input type="checkbox"/> (2) Denied: Dismissed by Plaintiff or by Agreement		<input type="checkbox"/> (3) Denied: Statute of Limitations <input type="checkbox"/> (4) Denied: FERES <input type="checkbox"/> (5) Denied: Not a Legitimate Claim, Non-Meritorious			<input type="checkbox"/> (6) Litigated: Decision for Plaintiff <input type="checkbox"/> (7) Litigated: Decision for U.S. <input type="checkbox"/> (8) Litigated: Out of Court Settlement (DOJ) <input type="checkbox"/> (9) Other <i>(Specify)</i>		
f. AMOUNT PAID		g. NUMBER OF CLAIMS FOR THIS INCIDENT			h. NUMBER OF PRACTITIONERS ON WHOSE BEHALF PAYMENT WAS MADE		

15. PROFESSIONAL REVIEW ASSESSMENT BY MEDICAL TREATMENT FACILITY									
a. ATTRIBUTION OF CAUSE <i>(X all that apply)</i>					b. EVALUATION OF CARE <i>(X one)</i>				
<input type="checkbox"/> (1) Facility or Equipment	<input type="checkbox"/> (2) Physician	<input type="checkbox"/> (3) Personnel other than Physician			<input type="checkbox"/> (1) Met	<input type="checkbox"/> (2) Not Met			
<input type="checkbox"/> (4) Management	<input type="checkbox"/> (5) System				<input type="checkbox"/> (3) Indeterminate				
c. IDENTIFY LOCATION OF CARE <i>(X one)</i>									
<input type="checkbox"/> (1) Ambulatory Clinic	<input type="checkbox"/> (2) Inpatient Clinic	<input type="checkbox"/> (3) Dental Service	<input type="checkbox"/> (4) Emergency	<input type="checkbox"/> (5) Other <i>(Specify)</i>					
d. INJURY SEVERITY <i>(X one)</i>					e. INJURY DURATION <i>(X one)</i>				
<input type="checkbox"/> (1) None	<input type="checkbox"/> (2) Some	<input type="checkbox"/> (3) Death	<input type="checkbox"/> (1) Temporary	<input type="checkbox"/> (2) Permanent	<input type="checkbox"/> (3) Cannot Predict/Undetermined				
16. ASSESSMENT									
a. AFIP REQUIRED?		<input type="checkbox"/> YES	<input type="checkbox"/> NO <i>(Evaluation of Care. X one)</i>		<input type="checkbox"/> (1) Met	<input type="checkbox"/> (2) Not Met	<input type="checkbox"/> (3) Indeterminate		
b. OTHER ASSESSMENTS									
(1) UCA or Name					<input type="checkbox"/> (1) Met	<input type="checkbox"/> (2) Not Met	<input type="checkbox"/> (3) Indeterminate		
(1) UCA or Name					<input type="checkbox"/> (1) Met	<input type="checkbox"/> (2) Not Met	<input type="checkbox"/> (3) Indeterminate		
(1) UCA or Name					<input type="checkbox"/> (1) Met	<input type="checkbox"/> (2) Not Met	<input type="checkbox"/> (3) Indeterminate		
(1) UCA or Name					<input type="checkbox"/> (1) Met	<input type="checkbox"/> (2) Not Met	<input type="checkbox"/> (3) Indeterminate		
c. FINAL OTSG DETERMINATION ACT OR OMISSION CODE(S) <i>(Refer to table on Page 4)</i>					d. CLINICAL SERVICE CODE				
<input type="checkbox"/> (1) Primary Act or Omission Code	<input type="checkbox"/> (2) Additional Act or Omission Code	<input type="checkbox"/> (1) Primary							
<input type="checkbox"/> (3) Additional Act or Omission Code	<input type="checkbox"/> (4) Additional Act or Omission Code	<input type="checkbox"/> (2) Secondary							
<input type="checkbox"/> (5) Additional Act or Omission Code	<input type="checkbox"/> (6) Additional Act or Omission Code	<input type="checkbox"/> (3) Tertiary							
17. STANDARD OF CARE (OTSG DETERMINATION) <i>(X one)</i>		<input type="checkbox"/> MET	18. NPDB REPORTED			<input type="checkbox"/> YES			
		<input type="checkbox"/> NOT MET				<input type="checkbox"/> NO			
19. REMARKS									

20. ACT OR OMISSION CODES

*NOC = Not Otherwise Classified

<p><u>DIAGNOSIS RELATED</u></p> <p>010 Failure to diagnose (i.e., concluding that patient has no disease or condition)</p> <p>020 Wrong diagnosis (misdiagnosis, i.e., original diagnosis is incorrect)</p> <p>030 Improper performance of test</p> <p>040 Unnecessary diagnostic test</p> <p>050 Delay in diagnosis</p> <p>060 Failure to obtain consent/lack of informed consent</p> <p>090 Diagnosis related (NOC)*</p>	<p><u>OBSTETRICS RELATED</u></p> <p>505 Failure to manage pregnancy</p> <p>510 Improper choice of delivery method</p> <p>520 Improperly performed vaginal delivery</p> <p>525 Improperly performed C-section</p> <p>530 Delay in delivery (induction or surgery)</p> <p>540 Failure to obtain consent/lack of informed consent</p> <p>550 Improperly managed labor (NOC)*</p> <p>555 Failure to identify/treat fetal distress</p> <p>560 Delay in treatment of fetal distress (i.e., identified but treated in untimely manner)</p> <p>570 Retained foreign body/vaginal/uterine</p> <p>580 Abandonment</p> <p>590 Wrongful life/birth</p> <p>590 Obstetrics related (NOC)*</p>
<p><u>ANESTHESIA RELATED</u></p> <p>110 Failure to complete patient assessment</p> <p>120 Failure to monitor</p> <p>130 Failure to test equipment</p> <p>140 Improper choice of anesthesia agent or equipment</p> <p>150 Improper technique/induction</p> <p>160 Improper equipment use</p> <p>170 Improper intubation</p> <p>180 Improper positioning</p> <p>185 Failure to obtain consent/lack of informed consent</p> <p>190 Anesthesia related (NOC)*</p>	<p><u>TREATMENT RELATED</u></p> <p>610 Failure to treat</p> <p>620 Wrong treatment/procedure performed (also improper choice)</p> <p>630 Failure to instruct patient on self care</p> <p>640 Improper performance of a treatment/procedure</p> <p>650 Improper management of course of treatment</p> <p>660 Unnecessary treatment</p> <p>665 Delay in treatment</p> <p>670 Premature end of treatment (also abandonment)</p> <p>675 Failure to supervise treatment/procedure</p> <p>680 Failure to obtain consent for treatment/lack of informed consent</p> <p>685 Failure to refer/seek consultation</p> <p>690 Treatment related (NOC)*</p>
<p><u>SURGERY RELATED</u></p> <p>210 Failure to perform surgery</p> <p>220 Improper positioning</p> <p>230 Retained foreign body</p> <p>240 Wrong body part</p> <p>250 Improper performance of surgery</p> <p>260 Unnecessary surgery</p> <p>270 Delay in surgery</p> <p>280 Improper management of surgical patient</p> <p>285 Failure to obtain consent for surgery/lack of informed consent</p> <p>290 Surgery related (NOC)*</p>	<p><u>MONITORING</u></p> <p>710 Failure to monitor</p> <p>720 Failure to respond to patient</p> <p>730 Failure to report on patient condition</p> <p>790 Monitoring related (NOC)*</p>
<p><u>MEDICATION RELATED</u></p> <p>305 Failure to order appropriate medication</p> <p>310 Wrong medication ordered</p> <p>315 Wrong dosage ordered of correct medication</p> <p>320 Failure to instruct on medication</p> <p>325 Improper management of medication program</p> <p>330 Failure to obtain consent for medication/lack of informed consent</p> <p>340 Medication error (NOC)*</p> <p>350 Failure to medicate</p> <p>355 Wrong medication administered</p> <p>360 Wrong dosage administered</p> <p>365 Wrong patient</p> <p>370 Wrong route</p> <p>380 Improper technique</p> <p>390 Medication administration related (NOC)*</p>	<p><u>BIOMEDICAL EQUIPMENT/PRODUCT RELATED</u></p> <p>810 Failure to inspect/monitor</p> <p>820 Improper maintenance</p> <p>830 Improper use</p> <p>840 Failure to respond to warning</p> <p>850 Failure to instruct patient on use of equipment/product</p> <p>860 Malfunction/failure</p> <p>890 Biomedical equipment/product related (NOC)*</p>
<p><u>INTRAVENOUS AND BLOOD PRODUCTS RELATED</u></p> <p>410 Failure to monitor</p> <p>420 Wrong solution</p> <p>430 Improper performance</p> <p>440 IV related (NOC)*</p> <p>450 Failure to insure contamination free</p> <p>460 Wrong type</p> <p>470 Improper administration</p> <p>480 Failure to obtain consent/lack of informed consent</p> <p>490 Blood product related (NOC)*</p>	<p><u>MISCELLANEOUS</u></p> <p>910 Inappropriate behavior of clinician (i.e., sexual misconduct allegation, assault)</p> <p>920 Failure to protect third parties (i.e., failure to warn/protect from violent patient behavior)</p> <p>930 Breach of confidentiality/privacy</p> <p>940 Failure to maintain appropriate infection control</p> <p>950 Failure to follow institutional policy or procedure</p> <p>960 Other (Provide detailed written description)</p> <p>990 Failure to review provider performance</p>